

REFERENCE TITLE: AHCCCS; healthcare group; waiting period

State of Arizona
House of Representatives
Forty-eighth Legislature
First Regular Session
2007

HB 2727

Introduced by
Representatives Prezelski, Farley, Gallardo, Lopes, Sinema, Senator
O'Halleran: Representatives Ableser, Hershberger, Lujan

AN ACT

AMENDING SECTION 36-2912, ARIZONA REVISED STATUTES; RELATING TO THE ARIZONA
HEALTH CARE COST CONTAINMENT SYSTEM.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1 Be it enacted by the Legislature of the State of Arizona:

2 Section 1. Section 36-2912, Arizona Revised Statutes, is amended to
3 read:

4 36-2912. Healthcare group coverage: program requirements for
5 small businesses and public employers: related
6 requirements: definitions

7 A. The administration shall administer a healthcare group program to
8 allow willing contractors to deliver health care services to persons defined
9 as eligible pursuant to section 36-2901, paragraph 6, subdivisions (b), (c),
10 (d) and (e). In the absence of a willing contractor, the administration may
11 contract directly with any health care provider or entity. The
12 administration may enter into a contract with another entity to provide
13 administrative functions for the healthcare group program.

14 B. Employers with one eligible employee or up to an average of fifty
15 eligible employees under section 36-2901, paragraph 6, subdivision (d):

16 1. May contract with the administration to be the exclusive health
17 benefit plan if the employer has five or fewer eligible employees and enrolls
18 one hundred per cent of these employees into the health benefit plan.

19 2. May contract with the administration for coverage available
20 pursuant to this section if the employer has six or more eligible employees
21 and enrolls eighty per cent of these employees into the healthcare group
22 program.

23 3. Shall have a minimum of one and a maximum of fifty eligible
24 employees at the effective date of their first contract with the
25 administration.

26 ~~C. The administration shall not enroll an employer group in healthcare~~
27 ~~group sooner than one hundred eighty days after the date that the employer's~~
28 ~~health insurance coverage under an accountable health plan is discontinued.~~
29 ~~Enrollment in healthcare group is effective on the first day of the month~~
30 ~~after the one hundred eighty day period. This subsection does not apply to~~
31 ~~an employer group if the employer's accountable health plan discontinues~~
32 ~~offering the health plan of which the employer is a member.~~

33 ~~D.~~ C. Employees with proof of other existing health care coverage who
34 elect not to participate in the healthcare group program shall not be
35 considered when determining the percentage of enrollment requirements under
36 subsection B of this section if either:

37 1. Group health coverage is provided through a spouse, parent or legal
38 guardian, or insured through individual insurance or another employer.

39 2. Medical assistance is provided by a government subsidized health
40 care program.

41 3. Medical assistance is provided pursuant to section 36-2982,
42 subsection I.

~~E.~~ D. An employer shall not offer coverage made available pursuant to this section to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e) as a substitute for a federally designated plan.

~~F.~~ E. An employee or dependent defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e) may participate in healthcare group on a voluntary basis only.

~~G.~~ F. Notwithstanding subsection B, paragraph 2 of this section, the administration shall adopt rules to allow a business that offers healthcare group coverage pursuant to this section to continue coverage if it expands its employment to include more than fifty employees.

~~H.~~ G. The administration shall provide eligible employees with disclosure information about the health benefit plan.

~~I.~~ H. The director shall:

1. Require that any contractor that provides covered services to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (a) provide separate audited reports on the assets, liabilities and financial status of any corporate activity involving providing coverage pursuant to this section to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e).

2. Beginning on July 1, 2005, require that a contractor, the administration or an accountable health plan negotiate reimbursement rates and not use the administration's reimbursement rates established pursuant to section 36-2903.01, subsection H, ~~as~~ as a default reimbursement rate if a contract does not exist between a contractor and a provider.

3. Use monies from the healthcare group fund established by section 36-2912.01 for the administration's costs of operating the healthcare group program.

4. Ensure that the contractors are required to meet contract terms as are necessary in the judgment of the director to ensure adequate performance by the contractor. Contract provisions shall include, at a minimum, the maintenance of deposits, performance bonds, financial reserves or other financial security. The director may waive requirements for the posting of bonds or security for contractors that have posted other security, equal to or greater than that required for the healthcare group program, with the administration or the department of insurance for the performance of health service contracts if funds would be available to the administration from the other security on the contractor's default. In waiving, or approving waivers of, any requirements established pursuant to this section, the director shall ensure that the administration has taken into account all the obligations to which a contractor's security is associated. The director may also adopt rules that provide for the withholding or forfeiture of payments to be made to a contractor for the failure of the contractor to comply with provisions of its contract or with provisions of adopted rules.

1 5. Adopt rules.

2 6. Provide reinsurance to the contractors for clean claims based on
3 thresholds established by the administration. For the purposes of this
4 paragraph, "clean claims" has the same meaning prescribed in section 36-2904.

5 ~~J.~~ I. With respect to services provided by contractors to persons
6 defined as eligible pursuant to section 36-2901, paragraph 6, subdivision
7 (b), (c), (d) or (e), a contractor is the payor of last resort and has the
8 same lien or subrogation rights as those held by health care services
9 organizations licensed pursuant to title 20, chapter 4, article 9.

10 ~~K.~~ J. The administration shall offer a health benefit plan on a
11 guaranteed issuance basis to small employers as required by this section.
12 All small employers qualify for this guaranteed offer of coverage. The
13 administration shall provide a health benefit plan to each small employer
14 without regard to health status-related factors if the small employer agrees
15 to make the premium payments and to satisfy any other reasonable provisions
16 of the plan and contract. The administration shall offer to all small
17 employers the available health benefit plan and shall accept any small
18 employer that applies and meets the eligibility requirements. In addition to
19 the requirements prescribed in this section, for any offering of any health
20 benefit plan to a small employer, as part of the administration's
21 solicitation and sales materials, the administration shall make a reasonable
22 disclosure to the employer of the availability of the information described
23 in this subsection and, on request of the employer, shall provide that
24 information to the employer. The administration shall provide information
25 concerning the following:

26 1. Provisions of coverage relating to the following, if applicable:

27 (a) The administration's right to establish premiums and to change
28 premium rates and the factors that may affect changes in premium rates.

29 (b) Renewability of coverage.

30 (c) Any preexisting condition exclusion.

31 (d) The geographic areas served by the contractor.

32 2. The benefits and premiums available under all health benefit plans
33 for which the employer is qualified.

34 ~~L.~~ K. The administration shall describe the information required by
35 subsection ~~K.~~ J of this section in language that is understandable by the
36 average small employer and with a level of detail that is sufficient to
37 reasonably inform a small employer of the employer's rights and obligations
38 under the health benefit plan. This requirement is satisfied if the
39 administration provides the following information:

40 1. An outline of coverage that describes the benefits in summary form.

41 2. The rate or rating schedule that applies to the product,
42 preexisting condition exclusion or affiliation period.

43 3. The minimum employer contribution and group participation rules
44 that apply to any particular type of coverage.

4. In the case of a network plan, a map or listing of the areas served.

~~M.~~ L. A contractor is not required to disclose any information that is proprietary and protected trade secret information under applicable law.

~~N.~~ M. At least sixty days before the date of expiration of a health benefit plan, the administration shall provide a written notice to the employer of the terms for renewal of the plan.

~~O.~~ N. The administration may increase or decrease premiums based on actuarial reviews of the projected and actual costs of providing health care benefits to eligible members. Before changing premiums, the administration must give sixty days' written notice to the employer. The administration may cap the amount of the change.

~~P.~~ O. The administration may consider age, sex, income and community rating when it establishes premiums for the healthcare group program.

~~Q.~~ P. Except as provided in subsection ~~R~~ Q of this section, a health benefit plan may not deny, limit or condition the coverage or benefits based on a person's health status-related factors or a lack of evidence of insurability.

~~R.~~ Q. A health benefit plan shall not exclude coverage for preexisting conditions, except that:

1. A health benefit plan may exclude coverage for preexisting conditions for a period of not more than twelve months or, in the case of a late enrollee, eighteen months. The exclusion of coverage does not apply to services that are furnished to newborns who were otherwise covered from the time of their birth or to persons who satisfy the portability requirements under this section.

2. The contractor shall reduce the period of any applicable preexisting condition exclusion by the aggregate of the periods of creditable coverage that apply to the individual.

~~S.~~ R. The contractor shall calculate creditable coverage according to the following:

1. The contractor shall give an individual credit for each portion of each month the individual was covered by creditable coverage.

2. The contractor shall not count a period of creditable coverage for an individual enrolled in a health benefit plan if after the period of coverage and before the enrollment date there were sixty-three consecutive days during which the individual was not covered under any creditable coverage.

3. The contractor shall give credit in the calculation of creditable coverage for any period that an individual is in a waiting period for any health coverage.

~~T.~~ S. The contractor shall not count a period of creditable coverage with respect to enrollment of an individual if, after the most recent period of creditable coverage and before the enrollment date, sixty-three consecutive days lapse during all of which the individual was not covered

1 under any creditable coverage. The contractor shall not include in the
 2 determination of the period of continuous coverage described in this section
 3 any period that an individual is in a waiting period for health insurance
 4 coverage offered by a health care insurer or is in a waiting period for
 5 benefits under a health benefit plan offered by a contractor. In determining
 6 the extent to which an individual has satisfied any portion of any applicable
 7 preexisting condition period, the contractor shall count a period of
 8 creditable coverage without regard to the specific benefits covered during
 9 that period. A contractor shall not impose any preexisting condition
 10 exclusion in the case of an individual who is covered under creditable
 11 coverage thirty-one days after the individual's date of birth. A contractor
 12 shall not impose any preexisting condition exclusion in the case of a child
 13 who is adopted or placed for adoption before age eighteen and who is covered
 14 under creditable coverage thirty-one days after the adoption or placement for
 15 adoption.

16 ~~U.~~ T. The written certification provided by the administration must
 17 include:

18 1. The period of creditable coverage of the individual under the
 19 contractor and any applicable coverage under a COBRA continuation provision.

20 2. Any applicable waiting period or affiliation period imposed on an
 21 individual for any coverage under the health plan.

22 ~~V.~~ U. The administration shall issue and accept a written
 23 certification of the period of creditable coverage of the individual that
 24 contains at least the following information:

25 1. The date that the certificate is issued.

26 2. The name of the individual or dependent for whom the certificate
 27 applies and any other information that is necessary to allow the issuer
 28 providing the coverage specified in the certificate to identify the
 29 individual, including the individual's identification number under the policy
 30 and the name of the policyholder if the certificate is for or includes a
 31 dependent.

32 3. The name, address and telephone number of the issuer providing the
 33 certificate.

34 4. The telephone number to call for further information regarding the
 35 certificate.

36 5. One of the following:

37 (a) A statement that the individual has at least eighteen months of
 38 creditable coverage. For THE purposes of this subdivision, "eighteen months"
 39 means five hundred forty-six days.

40 (b) Both the date that the individual first sought coverage, as
 41 evidenced by a substantially complete application, and the date that
 42 creditable coverage began.

43 6. The date creditable coverage ended, unless the certificate
 44 indicates that creditable coverage is continuing from the date of the
 45 certificate.

1 ~~W.~~ V. The administration shall provide any certification pursuant to
 2 this section within thirty days after the event that triggered the issuance
 3 of the certification. Periods of creditable coverage for an individual are
 4 established by presentation of the certifications in this section.

5 ~~X.~~ W. The healthcare group program shall comply with all applicable
 6 federal requirements.

7 ~~Y.~~ X. Healthcare group may pay a commission to an insurance producer.
 8 ~~To receive a commission, the producer must certify that to the best of the~~
 9 ~~producer's knowledge the employer group has not had insurance in the one~~
 10 ~~hundred eighty days before applying to healthcare group.~~ For the purposes of
 11 this subsection, "commission" means a one time payment on the initial
 12 enrollment of an employer.

13 ~~Z.~~ Y. On or before June 15 and November 15 of each year, the director
 14 shall submit a report to the joint legislative budget committee regarding the
 15 number and type of businesses participating in healthcare group and that
 16 includes updated information on healthcare group marketing activities. The
 17 director, within thirty days of implementation, shall notify the joint
 18 legislative budget committee of any changes in healthcare group benefits or
 19 cost sharing arrangements.

20 ~~AA.~~ Z. For the purposes of this section:

21 1. "Accountable health plan" has the same meaning prescribed in
 22 section 20-2301.

23 2. "COBRA continuation provision" means:

24 (a) Section 4980B, except subsection (f)(1) as it relates to pediatric
 25 vaccines, of the internal revenue code of 1986.

26 (b) Title I, subtitle B, part 6, except section 609, of the employee
 27 retirement income security act of 1974.

28 (c) Title XXII of the public health service act.

29 (d) Any similar provision of the law of this state or any other state.

30 3. "Creditable coverage" means coverage solely for an individual,
 31 other than limited benefits coverage, under any of the following:

32 (a) An employee welfare benefit plan that provides medical care to
 33 employees or the employees' dependents directly or through insurance,
 34 reimbursement or otherwise pursuant to the employee retirement income
 35 security act of 1974.

36 (b) A church plan as defined in the employee retirement income
 37 security act of 1974.

38 (c) A health benefits plan, as defined in section 20-2301, issued by a
 39 health plan.

40 (d) Part A or part B of title XVIII of the social security act.

41 (e) Title XIX of the social security act, other than coverage
 42 consisting solely of benefits under section 1928.

43 (f) Title 10, chapter 55 of the United States Code.

44 (g) A medical care program of the Indian health service or of a tribal
 45 organization.

1 (h) A health benefits risk pool operated by any state of the United
2 States.

3 (i) A health plan offered pursuant to title 5, chapter 89 of the
4 United States Code.

5 (j) A public health plan as defined by federal law.

6 (k) A health benefit plan pursuant to section 5(e) of the peace corps
7 act (22 United States Code section 2504(e)).

8 (l) A policy or contract, including short-term limited duration
9 insurance, issued on an individual basis by an insurer, a health care
10 services organization, a hospital service corporation, a medical service
11 corporation or a hospital, medical, dental and optometric service corporation
12 or made available to persons defined as eligible under section 36-2901,
13 paragraph 6, subdivisions (b), (c), (d) and (e).

14 (m) A policy or contract issued by a health care insurer or the
15 administration to a member of a bona fide association.

16 4. "Eligible employee" means a person who is one of the following:

17 (a) Eligible pursuant to section 36-2901, paragraph 6, subdivisions
18 (b), (c), (d) and (e).

19 (b) A person who works for an employer for a minimum of twenty hours
20 per week or who is self-employed for at least twenty hours per week.

21 (c) An employee who elects coverage pursuant to section 36-2982,
22 subsection I. The restriction prohibiting employees employed by public
23 agencies prescribed in section 36-2982, subsection I does not apply to this
24 subdivision.

25 (d) A person who meets all of the eligibility requirements, who is
26 eligible for a federal health coverage tax credit pursuant to section 35 of
27 the internal revenue code of 1986 and who applies for health care coverage
28 through the healthcare group program. The requirement that a person be
29 employed with a small business that elects healthcare group coverage does not
30 apply to this eligibility group.

31 5. "Genetic information" means information about genes, gene products
32 and inherited characteristics that may derive from the individual or a family
33 member, including information regarding carrier status and information
34 derived from laboratory tests that identify mutations in specific genes or
35 chromosomes, physical medical examinations, family histories and direct
36 ~~analysis~~ ANALYSES of genes or chromosomes.

37 6. "Health benefit plan" means coverage offered by the administration
38 for the healthcare group program pursuant to this section.

39 7. "Health status-related factor" means any factor in relation to the
40 health of the individual or a dependent of the individual enrolled or to be
41 enrolled in a health plan including:

42 (a) Health status.

43 (b) Medical condition, including physical and mental illness.

44 (c) Claims experience.

45 (d) Receipt of health care.

- 1 (e) Medical history.
- 2 (f) Genetic information.
- 3 (g) Evidence of insurability, including conditions arising out of acts
4 of domestic violence as defined in section 20-448.
- 5 (h) The existence of a physical or mental disability.
- 6 8. "Hospital" means a health care institution licensed as a hospital
7 pursuant to chapter 4, article 2 of this title.
- 8 9. "Late enrollee" means an employee or dependent who requests
9 enrollment in a health benefit plan after the initial enrollment period that
10 is provided under the terms of the health benefit plan if the initial
11 enrollment period is at least thirty-one days. Coverage for a late enrollee
12 begins on the date the person becomes a dependent if a request for enrollment
13 is received within thirty-one days after the person becomes a dependent. An
14 employee or dependent shall not be considered a late enrollee if:
- 15 (a) The person:
- 16 (i) At the time of the initial enrollment period was covered under a
17 public or private health insurance policy or any other health benefit plan.
- 18 (ii) Lost coverage under a public or private health insurance policy
19 or any other health benefit plan due to the employee's termination of
20 employment or eligibility, the reduction in the number of hours of
21 employment, the termination of the other plan's coverage, the death of the
22 spouse, legal separation or divorce or the termination of employer
23 contributions toward the coverage.
- 24 (iii) Requests enrollment within thirty-one days after the termination
25 of creditable coverage that is provided under a COBRA continuation provision.
- 26 (iv) Requests enrollment within thirty-one days after the date of
27 marriage.
- 28 (b) The person is employed by an employer that offers multiple health
29 benefit plans and the person elects a different plan during an open
30 enrollment period.
- 31 (c) The person becomes a dependent of an eligible person through
32 marriage, birth, adoption or placement for adoption and requests enrollment
33 no later than thirty-one days after becoming a dependent.
- 34 10. "Preexisting condition" means a condition, regardless of the cause
35 of the condition, for which medical advice, diagnosis, care or treatment was
36 recommended or received within not more than six months before the date of
37 the enrollment of the individual under a health benefit plan issued by a
38 contractor. Preexisting condition does not include a genetic condition in
39 the absence of a diagnosis of the condition related to the genetic
40 information.
- 41 11. "Preexisting condition limitation" or "preexisting condition
42 exclusion" means a limitation or exclusion of benefits for a preexisting
43 condition under a health benefit plan offered by a contractor.

1 12. "Small employer" means an employer who employs at least one but not
2 more than fifty eligible employees on a typical business day during any one
3 calendar year.

4 13. "Waiting period" means the period that must pass before a potential
5 participant or eligible employee in a health benefit plan offered by a health
6 plan is eligible to be covered for benefits as determined by the individual's
7 employer.